



# 20 Dollar Chiropractic

## New Patient Form

|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |     |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----|--|--|--|--|
| Name   |  |  |  |  |  |  |  |  |  | DOB   |  |  |  |  |     |  |  |  |  |
| Address  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |     |  |  |  |  |
| City   |  |  |  |  |  |  |  |  |  | State   |  |  |  |  | Zip |  |  |  |  |
| Cell Phone   |  |  |  |  |  |  |  |  |  | Text <input type="checkbox"/> Yes <input type="checkbox"/> No           |  |  |  |  |     |  |  |  |  |
| Home Phone   |  |  |  |  |  |  |  |  |  | Work Phone  |  |  |  |  |     |  |  |  |  |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female |  |  |  |  |  |  |  |  |  | Handedness <input type="checkbox"/> Right <input type="checkbox"/> Left |  |  |  |  |     |  |  |  |  |
| Email  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |     |  |  |  |  |

Reminder Preference  Call  
 Text  
 Email

Appt Preference  Mornings  
 Afternoons  
 Evenings

Employment Status  Full Time  
 Part Time  
 Self-Employed  
 Student  
 Other

Marital Status  Single  
 Engaged  
 Married  
 Divorced  
 Other

I understand the services are for Chiropractic care and/or wellness care and may not be covered under my insurance or government program. I understand and agree to abide by all terms and conditions at 20 Dollar Chiropractic.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Health History

Reason for seeking Chiropractic care: \_\_\_\_\_

Has your condition interfered with:

Sleep:  Yes  No

Work:  Yes  No

Other: \_\_\_\_\_

Describe any health problems and how long you have had them: \_\_\_\_\_

Are you under the care of any other doctor:  Yes  No

If yes, list the doctors and conditions being treated: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Past surgeries/dates: \_\_\_\_\_

Past accidents/dates: \_\_\_\_\_

Personal History

Occupation: \_\_\_\_\_

Do you smoke:  Yes  No

Do you drink:  Yes  No If yes, how often? \_\_\_\_\_

Do you exercise:  Yes  No If yes, how often? \_\_\_\_\_

Chiropractic History

Have you ever been to a chiropractor?  Yes  No

If yes, doctor's name \_\_\_\_\_

Date of last chiropractic visit \_\_\_\_\_ Condition treated for \_\_\_\_\_

Date of last chiropractic x-rays? \_\_\_\_\_

How long were you under chiropractic care? \_\_\_\_\_

Wellness Commitment

At \$20 Chiropractic, we are dedicated to achieving the goal of total lasting health for our patients. To better help you achieve this goal we need to understand your commitment to being healthy. Based on a scale of 10% to 100%, please circle your level of personal commitment to achieving and maintaining your total health and wellness

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How did you hear about us?